PART Ins 1902 MINIMUM STANDARDS FOR MEDICARE SUPPLEMENT POLICIES ISSUED PRIOR TO ADOPTION OF INSURANCE REGULATION 1905

Authority: RSA 400-A:15 II

Ins 1902.01 Purpose. The purpose of this part is to provide for the reasonable standardization of coverage and simplification of benefits of medicare supplement accident and sickness insurance policies and medicare supplement subscriber contracts in order to facilitate the public understanding and comparison and to eliminate provisions contained in such policies or contracts which may be misleading or confusing in connection either with the purchase of such policies or with the settlement of claims and to provide for full disclosures in the sale of such coverage.

Ins 1902.02 Applicability And Scope.

(a) Except as provided in paragraph (b) this part shall apply to:

(1) All medicare supplement policies and subscriber contracts advertised, solicited, delivered or issued for delivery in this state prior to July 1, 1992; and

(2) All certificates issued under group medicare supplement policies or subscriber contracts, which policies or contracts have been advertised, solicited, delivered or issued for delivery in this state prior to July 1, 1992.

(b) This part shall not apply to policies or contracts:

(1) Of one or more employers or labor organizations;

(2) Of the trustees of a fund established by one or more employers or labor organizations, or combination thereof;

(3) For employees or former employees, or a combination thereof;

(4) For members or former members, or a combination thereof, of the labor organizations; or

(5) Medicare supplement policies and certificates subject to Ins 1905.

Ins 1902.03 Definitions. For purposes of this part:

(a) "Applicant" means:

(1) In the case of an individual medicare supplement policy or subscriber contract, the person who seeks to contract for insurance benefits; and

(2) In the case of a group medicare supplement policy or subscriber contract, the proposed certificateholder.

(b) "Certificate" means any certificate issued under a group medicare supplement policy, which policy has been advertised, solicited, delivered or issued for delivery in this state.

(c) "Medicare supplement policy" means a group or individual policy of accident and health insurance or a subscriber contract of hospital service corporations, medical service corporations, or health service corporations which is advertised, marketed or designed primarily as a supplement to reimbursements under medicare for the hospital, medical or surgical expenses of persons eligible for medicare and includes:

(1) A policy or contract for one or more employers or labor organizations, or of the trustees of a fund established by one or more employers or labor organizations, or combination thereof, for employees or former employees, or combination thereof, or for members or former members, or combination thereof, of the labor organizations; or

(2) A policy or contract of any professional, trade or occupational association for its members or former or retired members, or combination thereof, if such association:

a. Is composed of individuals all of whom are actively engaged in the same profession, trade or occupation;

b. Has been maintained in good faith for purposes other than obtaining insurance; and

c. Has been in existence for at least 2 years prior to the date of its initial offering of such policy or plan to its members.

(d) "Medicare" means the "Health Insurance For The Aged Act," Title XVIII of the Social Security Amendments of 1965, as then constituted or later amended.

Ins 1902.04 Policy Definitions And Terms. No medicare supplement policy subject to this part shall contain definitions or terms respecting the matters set forth herein unless such definitions or terms conform to the requirements of this section as follows:

(a) "Accident, "accidental injury," or "accidental means" shall be defined to employ "result" language and shall not include words which establish an accidental means test or use words such as "external, violent, visible wounds," or similar words of description or characterization so that:

(1) The definition shall not be more restrictive than the following: "injury or injuries, for which benefits are provided, means accidental bodily injury sustained by the insured person which is the direct result of an accident, independent of disease or bodily infirmity or any other cause and occurrence while the insurance is in force."

(2) Such definition may provide that injuries for which benefits are provided under any workers' compensation, employer's liability or similar law, motor vehicle no-fault plan, unless prohibited by law.

(b) "Benefit period" or "medicare benefit period" shall not be defined as more restrictive than as that defined in the medicare program.

(c) "Convalescent nursing home," "extended care facility," or "skilled nursing facility" shall be defined in relation to its status, facilities and available services so that:

(1) A definition of such home or facility shall not be more restrictive than one requiring that it:

a. Be operated pursuant to law;

b. Be approved for payment of medicare benefits or be qualified to receive such approval, if so requested;

c. Be primarily engaged in providing, in addition to room and board accommodations, skilled nursing care under the supervision of a duly licensed physician;

d. Provide continuous 24-hours-a-day nursing service by or under the supervision of a registered graduate professional nurse R.N.; and

e. Maintains a daily medical record of each patient.

(2) The definition of such home or facility may provide that such term shall not be inclusive of:

a. Any home, facility or part thereof used primarily for rest;

b. A home or facility for the aged or for the care of drug addicts or alcoholics; or

c. A home or facility primarily used for the care and treatment of mental diseases, or disorders, or custodial or educational care.

(d) "Hospital" may be defined in relation to its status, facilities and available services or to reflect its accreditation by the Joint Commission on Accreditation of Hospitals so that:

(1) The definition of the term "hospital" shall not be more restrictive than one requiring that the hospital:

a. Be an institution operated pursuant to law;

b. Be primarily and continuously engaged in providing or operating, either on its premises or in facilities available to the hospital on a prearranged basis and under the supervision of a staff of duly licensed physicians, medical, diagnostic and major surgical facilities for the medical care and treatment of sick or injured persons on an inpatient basis for which a charge is made; and

c. Provide 24-hour nursing service by or under the supervision of registered graduate professional nurses.

(2) The definition of the term "hospital" may state that such term shall not be inclusive of:

a. Convalescent homes, convalescent, rest, or nursing facilities;

b. Facilities primarily affording custodial, educational or rehabilitory care; or

c. Facilities for the aged, drug addicts or alcoholics; or

d. Any military or veterans hospital or soldiers home or any hospital contracted for or operated by any national government or agency thereof for the treatment of members or ex-members of the armed forces, except for services rendered on an emergency basis where a legal liability exists for charges made to the individual for such services.

(e) "Medicare" means "The Health Insurance For The Aged Act, Title XVIII of the Social Security Amendments of 1965 as then constituted or later amended," or "Title I, Part I of Public Laws of 89-97, as enacted by the Eighty-ninth Congress of the United States of America and popularly known as The Health Insurance For The Aged Act, as then constituted and any later amendments or substitutes thereof," or words of similar import. Medicare consists of Part A and Part B. Part A refers to hospital benefits and Part B refers to Medicaid benefits.

(f) "Issuer" shall include insurance companies, fraternal benefit societies, nonprofit health service corporations, health maintenance organizations, and any other entity advertising, soliciting, delivering or issuing for delivery in this state medicare supplement policies or certificates.

(g) "Medicare eligible expenses" shall mean health care expenses of the kinds covered by medicare, to the extent recognized as reasonable by medicare. Payment of benefits by insurers for medicare eligible expenses may be conditioned upon the same or less restrictive payment conditions, including determinations of medical necessity as are applicable to medicare claims.

(h) "Mental or nervous disorders" shall not be defined more restrictively than a definition including neurosis, psychoneurosis, psychopathy, psychosis, or mental or emotional disease or disorder of any kind.

(i) "Nurses" may be defined so that the description of nurse is restricted to a type of nurse, such as a registered graduate professional nurse, R.N., a licensed practical nurse, L.P.N. or a licensed vocational nurse, L.V.N. If the words "nurse," "trained nurse" or "registered nurse" are used without specific instruction, then the insurer shall recognize the services of any individual who qualified under such terminology in accordance with the applicable statutes or administrative rules of the licensing or registry board of the state.

(j) "Physician" may be defined by including words such as "duly qualified physician" or "duly licensed physician." The use of such terms shall require an insurer to recognize and to accept, to the extent of its obligation under the contract, all providers of medical care and treatment when such services are within the scope of the provider's licensed authority and are provided pursuant to applicable laws.

(k) "Preexisting condition" means a condition for which medical advice or treatment was recommended by or received from a physician within the 6 month period preceding the effective date of the coverage of the insured person.

(l) "Sickness" shall not be defined to be more restrictive than the following:

(1) "Sickness means sickness or disease of an insured person which first manifests itself after the effective date of insurance and while the insurance is in force."

(2) The definition may be further modified to exclude sickness or disease for which benefits are provided under any workers' compensation, occupational disease, employer's liability or similar law.

(m) "Health care expenses" means expenses of health maintenance organizations associated with the delivery of health care services which are analogous to incurred losses or insurers. However, such expenses shall not include:

(1) Home office and overhead costs;

(2) Advertising costs;

(3) Commissions and other acquisitional costs;

(4) Taxes;

(5) Capital costs;

(6) Administrative costs; or

(7) Claims processing cost.

Ins 1902.05 Prohibited Policy Provisions.

(a) No medicare supplement policy shall limit or exclude coverage by type of illness, accident, treatment or medical condition, except as follows:

(1) Foot care in connection with corns, calluses, flat feet, fallen arches, weak feet, chronic foot strain, or symptomatic complaints of the feet;

(2) Alcoholism and drug addiction; and, mental or emotional disorders except as provided in RSA 415:18-a; RSA 419:5-a; and RSA 420:5-a;

(3) Illness, treatment or medical condition arising out of:

a. War or act of war, whether declared or undeclared; participation in a felony, riot or insurrection; service in the armed forces or units auxiliary thereto;

b. Suicide, sane or insane, attempted suicide or intentionally self-inflicted injury;

c. Aviation;

(4) Cosmetic surgery, except that "cosmetic surgery" shall not include reconstructive surgery when such service is incidental to or follows surgery resulting from trauma, infection or other diseases or disorders of the involved part;

(5) Care in connection with the detection and correction by manual or mechanical means of structural imbalance, distortion, or subluxation in the human body for purposes of removing nerve interference and the effects thereof, where such interference is the result of or related to distortion, misalignment or subluxation of, or in the vertebral column;

(6) Treatment provided in a governmental hospital; benefits provided under governmental program, except Medicaid, any state or federal workers' compensation, employers' liability or occupational disease law or any motor vehicle no-fault law; services rendered by employees of

hospitals, laboratories or other institutions; services performed by a member of the covered person's immediate family and services for which no charge is normally made in the absence of insurance;

(7) Dental care or treatment;

(8) Eyeglasses, hearing aids and examinations for the prescription or fitting thereof;

(9) Rest cures, custodial care, transportation and routine physical examinations; or

(10) Territorial limitations outside the United States provided, however, medicare supplement policies may not contain, when issued, limitations or exclusions of the type enumerated in this paragraph that are more restrictive than those of medicare. Medicare supplement policies may exclude coverage for any expense to the extent of any benefit available to the insured under medicare.

(b) No medicare supplement policy may use waivers to exclude, limit or reduce coverage or benefits for specifically named or described preexisting diseases or physical conditions.

(c) No medicare supplement policy shall include terms which provide that the policy may be cancelled or nonrenewed by the insurer solely on the grounds of deteriorated health.

(d) The terms "medicare supplement," "medigap" and words of similar import shall not be used unless the policy is issued in compliance with this part.

(e) No medicare supplement insurance policy, contract or certificate in force in this state shall contain benefits which duplicate benefits provided by medicare.

Ins 1902.06 Minimum Standards For Medicare Supplement Policies. No policy or certificate shall be advertised, solicited, delivered or issued for delivery in this state as a medicare supplement policy or certificate unless it meets or exceeds the following minimum standards:

(a) Medicare supplement policies and certificates, advertised, solicited, delivered or issued for delivery in this state shall comply with the following:

(1) A medicare supplement policy or certificate shall not exclude or limit benefits for losses incurred more than 6 months from the effective date of coverage because it involved a preexisting condition and shall not define a preexisting condition more restrictively than the definition found in Ins 1902.04(k);

(2) A medicare supplement policy or certificate shall not indemnify against losses resulting from sickness on a different basis than losses resulting from accidents;

(3) A medicare supplement policy or certificate shall provide that benefits designed to cover cost sharing amounts under medicare will be changed automatically to coincide with any changes in the applicable medicare deductible amount and co-payment percentage factors. Premiums may be changed to correspond with such benefit changes, but such changes in premiums may not be implemented prior to their approval by the commissioner pursuant to RSA 415:1;

(4) A "noncancellable," "guaranteed renewable," or "noncancellable and guaranteed renewable" medicare supplement policy or certificate shall not provide for termination of coverage of a spouse solely because of the occurrence of an event specified for termination of coverage of the insured, other than the nonpayment of premium;

(5) The rights of an insured with respect to or upon termination shall be as follows:

a. Except as authorized by the insurance commissioner an issuer shall neither cancel nor nonrenew a medicare supplement policy or certificate for any reason other than nonpayment of premium or material misrepresentation;

b. If a group medicare supplement insurance policy is terminated by the group policyholder and not replaced as provided in Ins 1902.06(a)(5)e., the insurer shall give written notice to certificateholders and offer an individual medicare supplement policy with at least the following choices:

1. An individual medicare supplement policy currently offered by the issuer having comparable benefits to those contained in the terminated group medicare supplement policy; and

2. An individual medicare supplement policy that provides only such benefits as are required to meet the minimum standards as defined in Ins 1902.06(b);

c. If membership in a group is terminated, the issuer shall give written notice and:

1. Offer the certificateholder such conversion opportunities as are described in Ins 1902.06(a)(5)e.; or

2. At the option of the group policyholders, offer the certificateholder continuation of coverage under the group policy;

d. The certificateholder shall have 30 days following receipt of written notice to make application for any conversion policy offered pursuant to this section;

e. If a group medicare supplement policy is replaced by another group medicare supplement policy purchased by the same policyholder; the issuer of the replacement policy shall offer coverage to all persons covered under the old group policy on its date of termination; and

f. Coverage under the replacement policy shall not result in any exclusion for preexisting conditions that would have been covered under the group policy that was replaced; and

(6) The termination of a medicare supplement policy or certificate shall be without prejudice to any continuous loss which commenced while the policy was in force, but the extension of benefits beyond the period during which the policy was in force may be predicated upon the continuous total disability of the insured, limited to the duration of the policy benefit period, if any, or payment of the maximum benefits.

(b) Medicare supplement policies, advertised, solicited, delivered or issued for delivery in this state shall meet or exceed the following minimum benefit standards:

(1) Coverage of part A medicare eligible expenses for hospitalization to the extent not covered by medicare for the 61st day through the 90th day in any medicare benefit period;

(2) Coverage for either all or none of the medicare part A inpatient hospital deductible amount;

(3) Coverage of part A medicare eligible expenses incurred as daily hospital charges during the use of Medicare's lifetime hospital inpatient reserve days;

(4) Upon exhaustion of all medicare hospital inpatient coverage including the lifetime reserve days, coverage of 90 percent of all medicare part A eligible expenses for hospitalization not covered by medicare subject to a lifetime maximum benefit of an additional 365 days;

(5) Coverage under medicare part A for the reasonable cost of the first 3 pints of blood or equivalent quantities of packed red blood cells, as defined under 42 CFR Part 409.87 unless replaced in accordance with 42 CFR Part 409.87 or already paid for under part B;

(6) Coverage for coinsurance amount of medicare eligible expenses under part B regardless of hospital confinement subject to a maximum calendar year out-of-pocket amount equal to the $100 medicare part B deductible; and

(7) Coverage under medicare part B for the reasonable cost of the first 3 pints of blood or equivalent quantities of packed red blood cells, as defined under 42 CFR Part 409.87 unless replaced in accordance with 42 CFR Part 409.87 or already paid under part A, subject to the medicare deductible amount.

Ins 1902.07 Required Disclosure Provisions.

(a) All medicare supplement policies shall include the following general rules:

(1) Medicare supplement policies shall include a renewal or continuation provision which shall be consistent with the type of contract issued, captioned and shall appear on the first page of the policy;

(2) A medicare supplement policy which provides for the payment of benefits based on standards described as "usual and customary," "reasonable and customary," or words of similar import, shall include a definition of such terms and an explanation of such terms in its accompanying outline of coverage;

(3) If a medicare supplement policy contains any limitations with respect to preexisting conditions, such limitations shall appear as a separate paragraph of the policy and be labeled as "preexisting condition limitations";

(4) All medicare supplement policies or certificates shall have a notice prominently printed on the first page of the policy or certificate attached thereto stating that the policyholder or certificateholder shall have the right to return the policy or certificate within 30 days of its delivery and to have the premium refunded if, after examination of the policy or certificate, the insured person is not satisfied for any reason;

(5) Except as otherwise provided in this part, the terms "medicare supplement," "medigap" and words of similar import shall not be used unless the policy is issued in compliance with Ins 1902.06; and

(6) Except for riders or endorsements by which the insurer effectuates a request made in writing by the insured, exercises a specifically reserved right under a medicare supplement policy, or is required to reduce or eliminate benefits to avoid duplication of medicare benefits, all riders or endorsements added to a medicare supplement policy after date of issue or at reinstatement or renewal which reduce or eliminate benefits or coverage in the policy shall require signed acceptance by the insured. After the date of policy issue, any rider or endorsement which increases benefits or coverage with a concomitant increase in premium during the policy term shall be agreed to in writing signed by the insured, unless the benefits are required by the minimum standards for medicare supplement policies, or if the increased benefits or coverage is required by law. Where a separate additional premium is charged for benefits provided in connection with riders or endorsements, such premium charge shall be set forth in the policy.

(b) The following notice requirements shall be met:

(1) As soon as practicable, but not later than 30 days prior to the annual effective date of any medicare benefit changes, every insurer, health care service plan or other entity providing medicare supplement insurance or benefits to a resident of this state shall notify its policyholders, contractholders and certificateholders of modifications it has made to medicare insurance policies or contracts;

(2) The notice required by the subparagraph above shall:

a. Include a description of revisions to the medicare program and a description of each modification made to the coverage provided under the medicare supplement insurance policy or contract; and

b. Inform each covered person as to when any premium adjustment is to be made due to changes in medicare;

(3) The notice of benefit modifications and any premium adjustments shall be in outline form and in clear and simple terms so as to facilitate comprehension; and

(4) Such notices shall not contain or be accompanied by any solicitation.

(c) Medicare supplement policies shall contain the following information:

(1) Insurers issuing medicare supplement policies or certificates for delivery in this state shall provide an outline of coverage to all applicants at the time application is made and, except for direct response policies, shall obtain an acknowledgment of receipt of such outline from the applicant; and

(2) If an outline of coverage is provided at the time of application and the medicare supplement policy or certificate is issued on a basis which would require revision of the of the outline, a substitute outline of coverage properly describing the policy or certificate shall accompany such policy or certificate when it is delivered and contain the following statement, in no less than 12

point type, immediately above the company name: "It is not identical to the outline of coverage provided upon application and the coverage originally applied for has not been issued;" and

(3) In addition to the requirements of subparagraphs (1) and (2), insurers issuing medicare supplement policies or certificates shall provide an outline of coverage for such medicare supplement policies or certificates to any prospective purchaser upon request.

(d) Notice regarding policies or subscriber contracts which are not medicare supplement policies shall include:

(1) The following in no less than 12 point type, either printed or attached to the first page of the outline of coverage delivered to insureds under the policy or subscriber contract, or if no outline of coverage is delivered, to the first page of the policy, certificate or subscriber contract delivered to insureds: "This, policy, certificate or subscriber contract, is not a medicare supplement policy or certificate. If you are eligible for medicare, review the medicare supplement buyer's guide available from the company" on the following policies issued for delivery in this state to persons eligible for medicare:

a. Any accident and sickness insurance policy or subscriber contract, other than a medicare supplement policy;

b. A policy issued pursuant to a contract under section 1876 of the Federal Social Security Act 42 U.S.C. Section 1395 et seq., disability income policy;

c. Basic, catastrophic or major medical expense policy; and

d. Single premium nonrenewable policy or other policy identified in Ins 1902.02(b) of this part.

Ins 1902.08 Requirements for Application Forms and Replacement Coverage.

(a) Application forms shall include the following questions designed to elicit information as to whether, as of the date of the application, the applicant has another medicare supplement policy or certificate in force or whether a medicare policy or certificate is intended to replace any other accident and sickness policy or certificate presently in force;

(1) "Do you have another medicare supplement insurance policy or certificate in force, including either a health care service contract or a health maintenance organization contract?"

(2) "Did you have another medicare supplement policy or certificate in force during the last 12 months?"

a. "If so, with which company?"

b. "If that policy lapsed, when did it lapse?"

(3) "Are you covered by Medicaid?"

(4) "Do you intend to replace any of your medical or health insurance coverage with this policy, certificate?"

(b) Or a supplementary application or other form signed by the applicant and agent, except where the coverage is sold without an agent, containing such questions may be used.

(c) Agents shall list on the applicant's application form, supplementary application or other form, whichever is used, any other health insurance policies they have sold to the applicant. In addition, the agent shall list those policies sold which are still in force and those policies sold in the past 5 years which are no longer in force.

(d) Upon determining that a sale will involve replacement, an insurer, other than a direct response insurer, or its agent, shall furnish the applicant, prior to issuance or delivery of the medicare supplement policy or certificate, a notice regarding replacement of medicare supplement insurance. One copy of such notice signed by the applicant and the agent, except where the coverage is sold without an agent, shall be provided to the applicant and an additional signed copy shall be retained by the insurer. A direct response insurer shall deliver to the applicant at the time of the issuance of the policy the notice regarding replacement of medicare supplement insurance.

Ins 1902.09 Loss Ratio Standards and Refund or Credit of Premiums.

(a) A group medicare supplement policy form or certificate form shall not be advertised, solicited, delivered or issued for delivery unless the policy form or certificate form can be expected, as estimated for the entire period for which rates are computed to provide coverage, on the basis of **:**

(1) Incurred claims experience; or

(2) Incurred health care expenses where coverage is provided by a health maintenance organization on a service rather than reimbursement basis; and

(3) Earned premiums for such period in accordance with accepted actuarial principals and practices, to return to policyholders and certificateholders in the form of aggregate benefits, not including anticipated refunds or credits, provided under the policy form at least 75 percent of the aggregate amount of premiums earned.

(b) An individual medicare supplement policy shall not be advertised, solicited, delivered or issued for delivery unless the policy form can be expected, as estimated for the entire period for which rates are computed to provide coverage, on the basis of:

(1) Incurred claims experience or incurred health care expenses where coverage is provided by a health maintenance organization on a service rather than reimbursement basis; and

(2) Earned premiums for such period in accordance with accepted actuarial principles and practices, to return to policyholders in the form of aggregate benefits, not including anticipated refunds or credits, provided under the policy form at least 65 percent of the aggregate amount of premiums earned.

(c) The return to policyholders and certificateholders in the form of aggregate benefits of at least 75 percent of the aggregate amount of premiums earned in the case of group policies and of at least 65 percent of the aggregate amount of premiums earned in the case of individual policies shall be deemed the loss ratio standards established by this rule.

(d) All filings of rates and rating schedules shall **:**

(1) Demonstrate that expected claims in relation to premiums comply with the requirements of this section when combined with actual experience to date; and

(2) Demonstrate if the filing is for a rate revision, that the anticipated loss ratio over the entire future period for which the revised premiums are computed to provide coverage can be expected to meet the appropriate loss ratio standard as determined by reference to Ins 1902.09 (a) in the case of a group policy or to Ins 1902.09 (b) in the case of an individual policy.

(e) For policies issued prior to July 1, 1992, expected claims in relation to premium shall meet:

(1) The originally filed anticipated loss ratio when combined with the actual experience since inception;

(2) The appropriate loss ratio requirement from Ins 1902.09 (a) or Ins 1902.09 (b) when combined with actual experience; and

(3) The appropriate loss ratio requirement from Ins 1902.09 (a) or Ins 1902.09 (b) over the entire future period for which the rates are computed to provide coverage.

(f) Rules applicable to refund or credit calculation reporting shall be as follows:

(1) With respect to Medicare supplement policies or certificates issued prior to July 1, 1992, the issuer shall make one refund or credit calculation combining the experience of all the issuer's individual policies beginning with experience after 12/31/96 and one refund or credit calculation combining the experience of all the issuer's group policies beginning with experience after 12/31/96;

(2) Each issuer shall collect the data contained in the applicable reporting form contained in Table 1900.03 and, using this reporting form, file the data with the commissioner.

(3) Reports shall be due on May 31 of each year.

(4) If, on the basis of the experience as reported, the benchmark ratio since inception of the reporting requirement, ratio 1 from line 7 of the reporting form contained in Table 1900.03, exceeds the adjusted experience ratio since inception of the same reporting requirement, ratio 3 from line 11 of the reporting form contained in Table 1900.03, then a refund or credit calculation shall be required. The refund calculation shall be done on a statewide basis.

(5) A refund or credit shall be made only when the benchmark loss ratio exceeds the adjusted experience loss ratio and the amount to be refunded or credited exceeds a de minimis level of $5.00 per individual policy or each individual certificate.

(6) The refund shall include interest pursuant to Ins 1905.13 (b)(4) from the end of the calendar year to the date of the refund or credit at a rate specified by the U.S. Secretary of Health and Human Services but in no event shall it be less than the average rate of interest for 13-week Treasury notes; and

(7) A refund or credit against premiums due shall be made by September 30 following the experience year upon which the refund or credit is based.

(g) An issuer of medicare supplement policies and certificates in this state shall file annually its premium rates, rating schedule and supporting documentation including ratios of incurred to earned premiums by policy duration.

(h) For the purpose of this section, policy forms shall be deemed to comply with the loss ratio standards if:

(1) For the most recent year, the ratio of the incurred losses to earned premiums, for policies or certificates which have been in force for 3 years or more is greater than or equal to the applicable percentages contained in this section;

(2) The expected losses in relation to premiums over the entire period for which the policy is rated comply with the requirements of this section; and

(3) An expected 3rd year loss ratio which is greater than or equal to the applicable percentage shall be demonstrated for policies or certificates in force less than 3 years.

(i) As soon as practicable, but prior to the effective date of enhancements in medicare benefits, every issuer of medicare supplement policies or certificates in this state shall file with the commissioner in accordance with the applicable filing procedures of this state the following items:

(1) Appropriate premium adjustments necessary to produce loss ratios as anticipated for the current premium for the applicable policies or certificates;

(2) Such supporting documents as necessary to justify the premium adjustments; and

(3) Any appropriate riders, endorsements or policy forms needed to accomplish the medicare supplement policy or certificate modification necessary to eliminate benefit duplications with medicare.

(j) An insurer shall make such premium adjustments as are necessary to produce an expected loss ratio under such policy or certificate as will conform with minimum loss ratio standards for medicare supplement policies.

(k) Such premium adjustments shall be expected to result in a loss ratio at least as great as that originally anticipated in the rates used to produce current premiums by the issuer for such medicare policies or certificates.

(l) No premium adjustment which would modify the loss ratio experience under the policy other than the adjustments described herein shall be made with respect to a policy or certificate at any time other than upon its renewal date or anniversary date.

(m) Riders, endorsements or policy forms filed pursuant to this section shall provide a clear description of the medicare supplement benefits provided by the policy or certificate.

(n) If presented with a request from an issuer for an increase in a rate for a policy or certificate form for which the experience under the form for the previous reporting period is not in compliance with the

applicable loss ratio standard, the commissioner, in order to gather information, shall, prior to any approval or disapproval of the request, conduct a public hearing in accordance with RSA 400-A:17 when:

(1) The issuer requests a public hearing, or

(2) At least ten policyholders or certificate holders request a public hearing.

Ins 1902.10 Standard for Claims Payment.

(a) An issuer shall comply with section 1882(c)(3) of the Social Security Act, as enacted by section 4081(b)(2)(c) of the Omnibus Budget Reconciliation Act of 1987, OBRA, 1987, Public Law No. 100-203, by:

(1) Accepting a notice from a medicare carrier on dually assigned claims submitted by participating physicians and suppliers as a claim for benefits in place of any other claim form otherwise required and making a payment determination on the basis of the information contained in that notice;

(2) Notifying the participating physicians or supplier and the beneficiary of the payment determination;

(3) Paying the participating physician or supplier directly;

(4) Furnishing, at the time of enrollment, each enrollee with a card listing the policy name, number and a central mailing address to which notices from a medicare carrier may be sent;

(5) Paying user fees for claim notices that are transmitted electronically or otherwise; and

(6) Providing to the Secretary of Health and Human Services, at least annually, a central mailing address to which all claims may be sent by medicare carriers.

Ins 1902.11 Permitted Compensation Arrangements.

(a) An insurer or other entity may provide commission or other compensation to an agent or other representative for the sale of a medicare supplement policy or certificate only if the first year commission or other first year compensation is no more than 200 percent of the commission or other compensation paid for selling or servicing the policy or certificate in the second year or period.

(b) The commission or other compensation provided in subsequent renewal years shall be the same as that provided in the second year or period.

(c) No entity shall provide compensation to its agents or other producers and no agent or producer shall receive compensation greater than the renewal compensation payable by the replacing insurer on renewal policies or certificates if an existing policy or certificate is replaced unless benefits of the new policy or certificate are substantially more favorable than the benefits under the replaced policy.

(d) For purposes of this section, "compensation" shall include pecuniary or nonpecuniary remuneration of any kind relating to the sale or renewal of the policy or certificate, including but not limited to bonuses, gifts, prizes, awards and finders' fees.

Ins 1902.12 Appropriations of Recommended Purchase and Excessive Insurance.

(a) In recommending the purchase or replacement of any medicare supplement policy or certificate an agent shall make reasonable efforts to determine the appropriateness of a recommended purchase or replacement.

(b) Any sale of medicare supplement coverage which will provide an individual more than one medicare supplement policy or certificate shall be prohibited; provided, however, that additional medicare supplement coverage may be sold if, when combined with that individual's health coverage already in force, it would insure no more than 100 percent of the individual's actual medical expenses covered under the combined policies.

Ins 1902.13 Reporting of Multiple Policies.

(a) On or before March 1 of each year, every insurer or other entity providing medicare supplement insurance coverage in this state shall report the following information for every individual resident of this state for which the insurer or entity has in force more than one medicare supplement insurance policy or certificate:

(1) Policy and certificate number; and

(2) Date of issuance.

(b) The items set forth above shall be grouped by individual policyholder.

Ins 1902.14 Prohibition Against Preexisting Conditions, Waiting Periods, Elimination Periods and Probationary Periods in Replacement Policies or Certificates. If a medicare supplement policy or certificate replaces another medicare supplement policy or certificate, the replacing insurer shall waive any time periods applicable to preexisting conditions, waiting periods, elimination periods and probationary periods in the new medicare supplement policy for similar benefits to the extent such time was spent under the original policy.

Ins 1902.15 Benefit Conversion Requirements During Transition.

(a) Benefits eliminated by operation of the Medicare Catastrophic Coverage Act of 1988 transition provisions shall be restored.

(b) For medicare supplement policies subject to the minimum standards adopted by the states pursuant to Medicare Catastrophic Coverage Act of 1988, the minimum benefits shall be:

(1) Coverage of part A medicare eligible expenses for hospitalization to the extent not covered by medicare from the 61st day through the 90th day in any medicare benefit period;

(2) Coverage of either all or none of the medicare part A inpatient hospital deductible amount;

(3) Coverage of part A medicare eligible expenses incurred as daily hospital charges during use of Medicare’s lifetime hospital inpatient reserve days;

(4) Upon exhaustion of all medicare hospital inpatient coverage including the lifetime reserve days, coverage of 90 percent of all medicare part A eligible expenses for hospitalization not covered by medicare subject to a lifetime maximum benefit for an additional 365 days; and

(5) Coverage under medicare part A for the reasonable cost of the first 3 pints of blood or equivalent quantities of packed red blood cells, as defined under 42 CFR Part 409.87 unless replaced in accordance with 42 CFR Part 409.87 or already paid for under part B.

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